DEPARTMENT OF THE ARMY
Fort Carson Medical Department Activity
1650 Cochrane Circle
Fort Carson, Colorado 80913-4604

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MEDDAC PAM 40-41

SUBJECT: FALLS PREVENTION PROTOCOL

History. This is the first publication of this publication

Summary. This publication covers the policy and procedures for the risk screening/assessment for patient falls.

Applicability. This publication applies to all MEDDAC activities at Fort Carson, CO.

Proponent and exception authority. The proponent of this publication is the Patient Safety Committee. The proponent has the authority to approve exceptions to this publication consistent with controlling directives.

FOR THE COMMANDER

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DISTRIBUTION

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1. **PURPOSE**: This PAM provides guidance to all USA MEDDAC Fort Carson staff.

2. **REFERENCES:**

a. Evans Army Community Hospital 2003 Failure Mode and Effect Analysis on Patient Falls, July 23, 2003.

b. The National Center for Patient Safety Web Site, *http://www.patientsafety.gov/* Department of Veterans Affairs' (VA), March 3, 2006.

c. Joint Commission 2006 Compressive Accreditation Manual for Hospitals Comprehensive Accreditation Manual for Hospitals, latest edition.

3. **SCOPE:**

a. This PAM applies to all personnel within the USA MEDDAC Fort Carson who have responsibilities for patient care.

1-4. **Explanation of Terms:**

a. A fall is defined as a sudden, unexplained, change in position, in which the patient comes to rest on the floor or another surface lower than the patient's previous position. Although safety measures are taken with all patients to prevent falls, patients at high risk are identified during assessment.

b. Yearly self screening tool is defined as the tool used in the primary care out patient clinics that patients complete to update their personnel needs and assessment of their health status.

c. A falls assessment is defined as a formal falls evaluation conducted by health care professionals, (HCP) on inpatients for the purpose of spotting a falls risk.

1-5 **Responsibilities**:

a. The Hospital Commander will ensure that all HCPs understand and comply with this PAM.

b. Patient Safety Committee will track, trend, and report all patient falls in the facility at the Patient Safety Committee meeting.

c. The hospital safety officer and the Environment of Care Functional Management Team, (FMT) will conduct a yearly environmental risk analysis for falls in the outpatient arenas and furnish a report to the Patient Safety Committee.

d. The Human Resource FMT and the education section of the S2/3 Division will ensure that the staff is educated and tested yearly, by including elements of this Pam in MEPs.

e. Primary care providers will ensure that patients who identify themselves as having a risk for falling receive appropriate care.

f. When witnessing or finding a patient who has fallen every staff member has the responsibility of assisting the patient, notifying the patients' care provider, and initiating an e-4106.

4. **Patient falls screening and assessments**:

a. Out Patient Areas

1. All outpatients are screened annually using the specifically colored yearly self screening tool (2005 Mellow Yellow, 2006 True Blue, and so on) at their primary care clinic.

2. Patients who identify themselves as having a risk of falling will have that risk addressed by their primary care provider, (PCP).

3. The PCPs and staff must recognize that some patients have an increased risk of falling due to diagnosis, treatment, or age despite a negative response on the self screening tool.

b. In patient Areas

1. All inpatients are initially assessed for risk of falling at the time of admission using the EACH Initial Assessment Form (MCXE FORM DON 40-3x(1). Subsequent to that initial falls risk assessment, all patients identified at risk of falling are reassessed daily and when transferred from one unit to another. Routine reassessments are documented on the Patient Activities Flow sheet (MCXE FORM DON 40-3x(2). Research has shown that certain deficits associated with musculoskeletal, genitourinary, gastrointestinal, neurological and functional status areas can predispose individuals to falls. For example, grasping for support while ambulating, bowel or bladder incontinence, use of assistive devices and inability to comprehend or follow safety instructions are factors that increase an individual's risk for a falls event. Administration of certain medications, such as narcotics, sedatives and antihypertensive can increase a patient's risk for falls. During the initial and follow-up fall assessment phases, caregivers shall give special consideration to assessing the systems named above and identified by an (✯) on the Initial Assessment Form (MCXE FORM DON 40-3x(1). The caregiver will document findings in each system and annotate the final Falls Risk Assessment and initial plan on page six of the Initial Assessment Form.

2. When it has been determined that the patient is at risk of falling, all of the falls protocol procedures described below shall be considered for implementation at anytime, and the plan continually documented and updated in the patient's record. The caregiver will determine the most appropriate falls prevention measures to implement based on the individual patient situation and communicate those measures on the Patient Activities Flow sheet. The (*) procedures are mandatory for all patients deemed at risk for falls.

5. **IN PATIENT CARE AREAS FALLS PREVENTION PROCEDURES.**

Note: Asterisk entries are mandatory for patients deemed at risk for falls.

a. * Place an orange band on patient and orange sticker on patient's door and chart to communicate the falls risk status.

b. * Ensure the call light button is within the patient's reach at all times and instruct the patient to ring for assistance.

c. * Falls risk reassessed and documented daily and upon transfer to another unit.

d. * Ensure the patient wears hospital issue non-skid footwear when up-right.

e. * Position personal items and assistive/support devices within reach of the patient.

f. Review the Falls Information Sheet with the patient and family. Render any necessary explanation to the patient and family, and include them in the Falls Prevention Hospital Plan (Enclosure A). Place a signed copy of the Falls Information Sheet in the patient's record.

g. Review the "Patient and Family Home Care Falls Prevention Sheet" before discharge and provide a copy to the patient and family members. (Enclosure B)

h. * Lock the bed wheels and maintain the bed in the lowest position.

i. Use a seat-belt when patient is in a chair or strap when on a gurney.

j. Encourage a family member or friend to stay with the patient whenever possible.

k. Whenever possible, place the patient and bed close to, or in line of sight of, the nurse's station.

l. Offer toileting assistance on a routine/frequent basis and/or place a bedside commode next to the bed.

m. * Escort all falls risk patients to their clinic visits (Radiology, OT, PT, and so on) and do not leave them unattended.